CHRISTOPHER WAYNE LESTER

10 OF 14

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Today's Date : 12/13/2002

Patient Account Number :

Patient Name : CHRISTOPHER W LESTER

Patient HICN : [redacted]3340A Patient DOB : [redacted]/1971

PO BOX 1113
DANVILLE WV 25053 Patient Phone : (304) 369-6657

Diagnosis Codes: 1) 724.2 2) 780.39 3) 4)

Supplier's Medicare #: 0956640001

Ordering Provider Info : E13868 JOHN SNYDER

From DOS	To DOS	POS	Units	HCPCS	Mods	DX	Charge	CMN
09/04/02	09/04/02	12	1.0	K0006	RRKH	1	110.00	Y
10/04/02	10/04/02	12	1.0	K0006	RRKI	1	110.00	
Totals							220.00	

Today's Date : 12/13/2002

Patient Account Number :

Patient Name : CHRISTOPHER W LESTER

Patient HICN : [redacted]3340A Patient DOB : [redacted]/1971

PO BOX 1113
DANVILLE WV 25053 Patient Phone : (304) 369-6657

Diagnosis Codes: 1) 724.2 2) 780.39 3) 4)

Supplier's Medicare #: 0956640001

Ordering Provider Info : D49415 EBENEZER OBENZA

From DOS	To DOS	POS	Units	HCPCS	Mods	DX	Charge	CMN
08/09/02	08/09/02	12	1.0	E0148	NU	1	150.00	
Totals :							150.00	

Today's Date : 12/20/2002

Patient Account Number :

Patient Name : CHRISTOPHER W LESTER

Patient HICN : [redacted]3340A Patient DOB : [redacted]/1971

PO BOX 1113
DANVILLE WV 25053 Patient Phone : (304) 369-6657

Diagnosis Codes: 1) 724.2 2) 780.39 3) 4)

Supplier's Medicare #: 0956640001

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From DOS	To DOS	POS	Units	HCPCS	Mods	DX	Charge	CMN
09/04/02	09/04/02	12	1.0	K0006	RRKH	1	110.00	Y
10/04/02	10/04/02	12	1.0	K0006	RRKI	1	110.00	
Totals :							220.00	

Boone Home Care Supplies
327 State Street
Madison, WV 25130
(304)369-7964 Fax (304)369-7005
Kathleen Ellis Owner/Manager

NAME: CHRISTOPHER LESTER **DATE:** 11-11-02

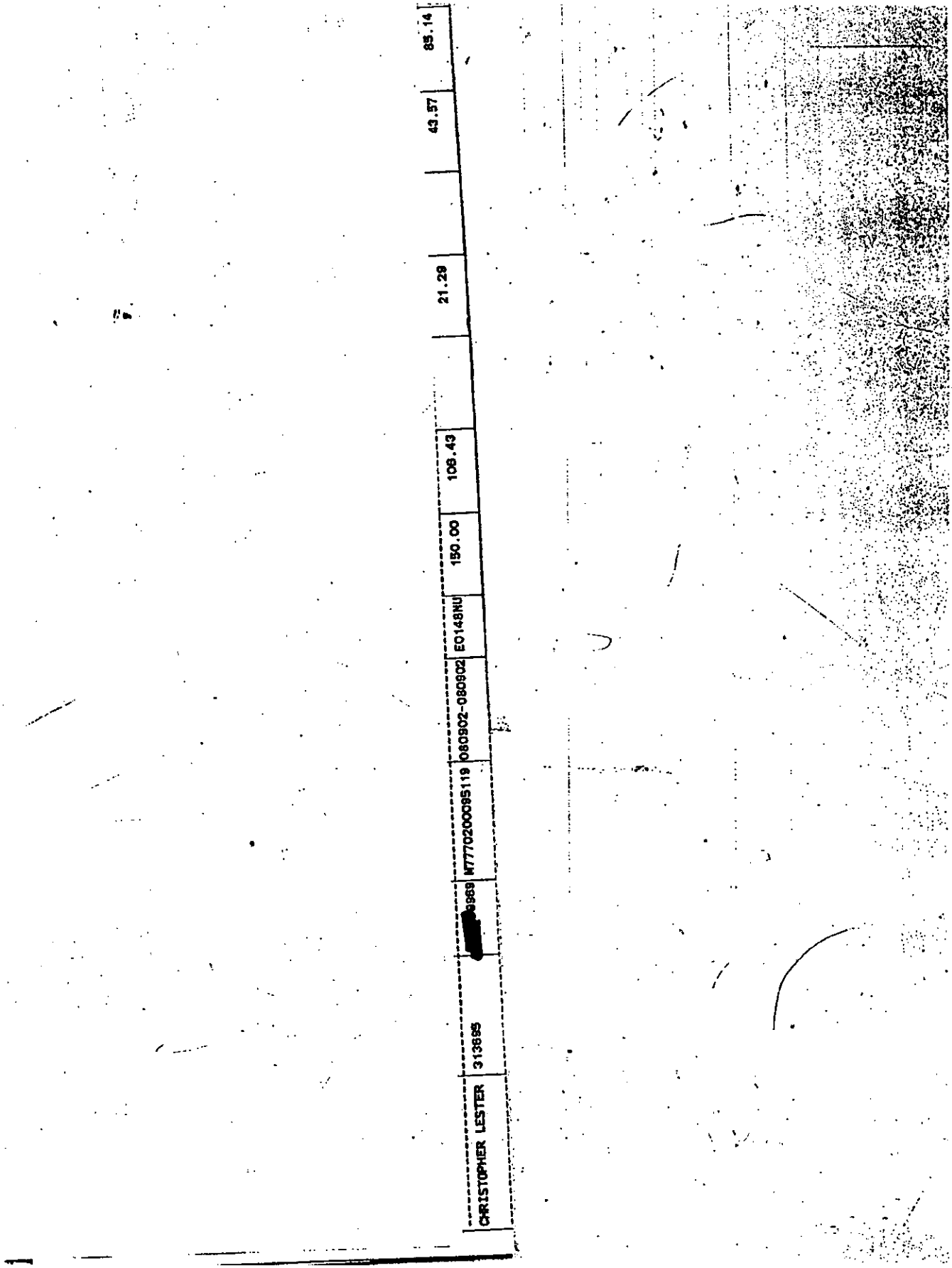
ADDRESS: PO BOX 1113
DANVILLE, WV 25053

PATIENT'S RESPONSIBILITY

BILLING DATE	ITEMS	QUANTITY	INSURANCE PAYMENT	CO-INSURANCE	DEDUCTIBLE	BALANCE DUE
08-09-02	HEAVY DUTY WALKER	1	150.00	21.29	21.29	21.29

THIS AMOUNT WAS APPLIED TO YOUR DEDUCTIBLE. TOTAL$21.29

500688.061.0040



500688.061.0041

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]9969

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LESTER CHRISTOPHER	3. PATIENT'S BIRTH DATE MM DD YY [redacted] 1971 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) LESTER APRIL	
5. PATIENT'S ADDRESS (No., Street) PO BOX 1113	6. PATIENT RELATIONSHIP TO INSURED Self Spouse X Child Other	7. INSURED'S ADDRESS (No., Street) SAME	
CITY DANVILLE	STATE WV	8. PATIENT STATUS Single Married Other	CITY	STATE
ZIP CODE 25053	TELEPHONE (Include Area Code) (304) 369-6657	Employed Full-Time Student Part-Time Student	ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 7770	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME WVAPEIA	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME ACORDIA NATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE EBENEZER OBENZA	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 724.2 2. 780.39 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 08 09 02 08 09 02	12		E0148	NU	1,2	150 00	1				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN 55-073-9015-001 X	26. PATIENT'S ACCOUNT NO. 313695	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 150.00	29. AMOUNT PAID $	30. BALANCE DUE $ 150.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Kathleen S. Ellis SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 10/02/02	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (304)369-7964 BOONE HOMECARE SUPPLIES 327 STATE STREET MADISON WV 25130 55-0739015,001 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

500688.061.0042

313695

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 8-9-02

NAME Christopher lester

ADDRESS [redacted] 3340

CITY, STATE, ZIP

DOB [redacted] -1971 DOI 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2				
3	1	Heavy Duty		
4		Walker		
5		#6004070-2		
6		E0148		
7				
8		7242		
9				
10		78039		
11				
12		Ultraviolet Allergy		
13				
14				
15		2000046841		
16				
17				
18				

RECEIVED BY April Lester

TAX

TOTAL

35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

EBENEZER OBENZA 00/00/00 00/00/00

7242 78039

2000046841

08/09/02 12 E0148 NU 150.00 01

313695 150.00 0.00 150.00

Signature On File
09/13/02 5507390150

500688.061.0044

ATLANTA CARE CENTER
3567 PKWY LN
STE 200
NORCROSS, GA 30092
(888)440-7342

Intracorp

OCTOBER 14, 2002

BOONE HOMECARE SUPPLIES
327 STATE ST
MADISON, WV 25053

Patient: CHRISTOPHER LESTER
Payor: ACORDIA NATIONAL
Plan Participant: APRIL LESTER
Participant ss[redacted]-9969
Policy #:
Employer: WV PEIA
Case Reference #: 19605411

This letter is to confirm our phone conversation regarding the above named patient.

SERVICE HEAVY DUTY WHEELCHAIR
REQUESTED COST 89.30
APPROVED COST 89.30
UNITS 10 Monthly
REQUEST DATE FROM 09/04/2002 TO 07/04/2003

The above services have been recommended to the employee's claims payor for reimbursement under the provisions of his/her benefit plan. Charges incurred will be payable in accordance with the plan provisions, provided the patient is covered under the plan at the time. If a change in service is necessary, it is the physician's and/or provider's responsibility to contact me at (888)440-7342.

This letter does not confirm eligibility, benefits or contract limitations. You are responsible for confirming eligibility and benefit coverage for the above services with the health claim payor.

For service reimbursement, attach a copy of this letter with each invoice.

Sincerely,
PEGGY DICKERSON
Case Manager

c:
ACORDIA NATIONAL

CALLING INSURANCE COMPANIES...

DATE: 9-10-02

TIME: 9:25 am — I have to call case management

TALKED TO: Rebecca

PATIENT: Christopher Lester ID#: [redacted]5340
20000 46841

PROBLEM:
Called to see if workers' comp will pay for wheelchair

Donna ~~Currie~~ Curry
800-231-4850

RESPONSE:
Back & neck injury
If it is a compensable injury then the wheelchair would be covered.

Seizure disorder - no it won't be covered

March 10-2000 - neck + chest
Aug 10, 94 - Back injury

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address

CHRISTPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number: (304) 369-6657

4. Social Security Number: [redacted]-3340

5. Date of Birth: [redacted]1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
Chron have acm bronchitis & COPD

8a. Type of Prescription
[X] Original (New)
[ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 08/30/02
Ending Date: 08/29/03

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

[ ] Tank O_2 With Flowmeter and Humidifier
[ ] O_2 Concentrator
[ ] O_2 Liquid System
[ ] Portable Unit (Gaseous)
[ ] O_2 Liquid System With Portable Liquid

9b. Other DME
[ ] Manual Hospital Bed (11c.)
[ ] Semi-electric Hospital Bed (11c.)
[ ] Nebulizer with Motor (11a.)
[ ] Commode (11f.)
[X] Wheelchair (11g.)
[ ] Other (Explain in item no. 12.)

9c. Prescription for Medical Services
[ ] Pulmonary Rehabilitation Services (See 11e.)
Level: _____
[ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic
Results: (Best Effort)

	Predicted	Bronchodilation Before	Bronchodilation After
FEV_1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic
Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ___ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

Form CM-893
Rev. Dec. 1990

500688.061.0047

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 80 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment.
Objective test requirements: for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. **ALL CMN supportive test results:** must be dated 2 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:
K0006: HEAVY DUTY WHEELCHAIR

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)
JOHN M SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304)369-5170

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☑ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 8 30 8 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 9 04 02 (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date: 9/13/02

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Telephone: (304) 369-5170 DEA #AS 3212329

JOHN M. SNYDER, D.O.

705 Madison Avenue Madison, WV 25130

Name Chrystal Lester Date 8-20-8

Address

℞

Wheelchair. wt. 300 ht. 5'8

Extra wide

[signature] D.O.

This prescription may be filled with a generically equivalent drug product unless the words "Brand Necessary" or "Brand Medically Necessary" are written, in the practitioner's own handwriting, on this prescription form.

☑ Label

Refill - 0 - 1 - 2 - 3 - 4 - PRN

CALLING INSURANCE COMPANIES...

DATE: 10-8-02

TIME: @ 10:07am

TALKED TO: Velinda

PATIENT: Christopher Lester ID#: [redacted]9969

PROBLEM:
I called to see if wheelchair needed to be precerted.

RESPONSE:
7-1-99 off
225 ded
1,800 out of ded.
80% they are covered
It will need to be precerted if it is longer than 3 mth rental or 4,000 or more purchase price

438.10 - Speech & language deficits unspecified

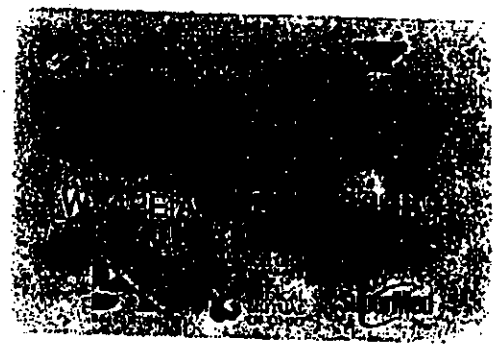
724.2 - Lumbago

780.39 - Seizure Disorder

Talked to Maggie - 10-8-02 10:10am

called to get w/chair pre-certed

Case #: 19605411



10:20 am
Talked to Sue
No limit on Supplies
Must have MSF signed
by physician.

ID #: [redacted]9969
Group #: 7770
Acordia National
Medical Claims 1-800-440-7342

[redacted]

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
CHRISTOPHE W LESTER
MEDICARE CLAIM NUMBER SEX
[redacted]3340-A MALE
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 09-01-2002
MEDICAL (PART B) 09-01-2002
SIGNATURE Christopher W. Lester

Medicare is secondary

work: 369-9246

wt. 300 lbs

ht: 5'8

Boone Home Care Supplies
327 State Street
Madison, WV 25130
(304)369-7964 Fax (304)369-7005

Physician's Order

Date: 08-15-02

Customer Name: CHRISTOPHER LESTER HINC: [redacted]-3340

Customer Address: PO BOX 1113 DOB: [redacted]1971

DANVILLE, WV 25053

THE FOLLOWING DURABLE MEDICAL EQUIPMENT HAS BEEN PRESCRIBED BY ME FOR THE ABOVE PATIENT:

1. GRAB BAR HCPC: E0241
2. ~~HEAVY DUTY SHOWER BENCH~~ HCPC: E0245
3. HEAVY DUTY WALKER HCPC: E0148
4. HCPC:

Length of time needed (lifetime=99): Months: 12

Diagnosis: OLD BACK INJURY WITH CHRONIC PAIN, SEIZURE DISORDER

Is the patient bed or room confined (yes or no): YES

Physician signature: [signature] Date: 9/16/02

Physician Name And Address:

EBENEZER OBENZA
333 LAIDLEY STREET
CHARLESTON, WV 25301

PHONE: (304)347-6640 UPIN: D49415

HCFA MANDATES THE COMPLETION OF A CERTIFICATE OF MEDICAL NECESSITY AS WELL AS THE ORDER FORM ON SOME DME ITEMS.

313719

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 8-23-02

NAME Christopher Lester
ADDRESS [redacted] 3340
CITY, STATE [redacted]-1971 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2			
3	6 Tens Lotion	45	00
4			
5			
6	2 Biofreeze	20	00
7			
8			
9			
10	A4595 DU 2-	65	00
11			
12	John H Snyder		
13		Billed	
14	7242		
15			
16	2000046841	~~8-16-02~~	
17		8-23-02	
18			

RECEIVED BY David Lester
TAX
TOTAL

35805

500688.061.0055

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

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X

X West Virginia Workers Comp.

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JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

08/23/02 12 A4595 NU 65.00 02

Refile w/ date of injury 3-10-00

Rebilled 11-02

313719 65.00 0.00 65.00

Signature On File
08/23/02

5507390150

0

500688.061.0056

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

629678

DATE 9-24-02

NAME Christopher Lester

ADDRESS [redacted] 3340 D.O.I. 03/10/2000

CITY, STATE, ZIP D.O.B. [redacted] 1971

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RTD.	PAID OUT
							1243.00

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	30	Freedom Condom Caths #8200 24 in. A4358 NU 30		55.00
2	2	Leg Bag #15010 A4358 NU		
3	2	Night time Drain Wrap #5900 2		14.00
4	1	Extension tubing #9803 A4357 NU 2		20.00
5		- Frederick C. Martinez		
6		-596.54		
7		2000041084		
8				
9				
10				
11				
12				
13				
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15				
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RECEIVED BY Paul Lester

TAX

TOTAL

adams 25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

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X West Virginia Workers Comp.

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FREDERICK C. MARTINE 00/00/00 00/00/00

59654

2000046841

09/24/02	12	A4358 NU	55.00	30
09/24/02	12	A4358 NU	14.00	02
09/24/02	12	A4357 NU	20.00	02
09/24/02			0.00	00

629678 89.00 0.00 89.00

Signature On File

500688.061.0058

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

629764

DATE 9-24-02

NAME Christopher Lester

ADDRESS [redacted] 3346 D.O.I. 03/10/00

CITY, STATE, ZIP D.O.B. [redacted] 1971

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
					12935		

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	2	Disposable electrodes @1.00		2.00
2	1	Biofreeze		12.00
3	2	Tens Unit Lotion @7.50		15.00
4	2	Electrodes #2404 @12.00		24.00
5	1	Electrode #12225		10.00
6	1	Electrode #1640		12.00
7		A4595 100 2		
8				
9		John M. Snyder		
10				
11		M24.2		
12				
13				
14		2000041041		75.00
15				
16				
17				
18				

RECEIVED BY April Lester

TAX

TOTAL

25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

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X West Virginia Workers Comp.

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JOHN M. SNYDER 00/00/00 00/00/00

7242

2000046841

09/24/02 12 A4595 NU 75.00 02

629764 75.00 0.00 75.00

Signature On File
09/27/02 5507390150

500688.061.0060

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

327401

DATE 8-9-02

NAME Christopher Lester

ADDRESS [redacted] 3340

CITY, STATE, ZIP

DOB [redacted] 1971 DOI 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2			
3			
4	#1574 DNI 24"		
5	Grab Bar.		
6			
7	E0241 NU 1	30.00	
8			
9			
10			
11	7242		
12			
13	780.39		
14			
15	Ebenezer Owensa.		
16			
17	200007684/		
18			
	TAX		
	TOTAL		

RECEIVED BY Neil Lester

25805

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LESTER CHRISTOP X

[redacted]3340

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X West Virginia Workers Comp.

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EBENEZER OBENZA 00/00/00 00/00/00

7242 78039

2000046841

08/09/02 12 E0241 NU 30.00 01

327401 30.00 0.00 30.00

Signature On File
09/13/02 5507390150

500688.061.0062

313718

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 8-9-02

NAME Christopher Lester
ADDRESS [redacted] 3340
CITY, STATE, ZIP
DOB [redacted] 1971 DOI 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2			
3	1 Heavy Duty Shaver		
4	Bench		
5			
6	Parts DU 1-150.00		
7			
8			
9			
10	97342		
11			
12	780.39 Obenza		
13			
14	Ebenezer Obenza		
15			
16	200046841		
17			
18			
RECEIVED BY	April Lester	TAX	
		TOTAL	

35805

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LESTER CHRISTOP X

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X West Virginia Workers Comp.

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EBENEZER OBENZA 00/00/00 00/00/00

7242 78039

2000046841

08/09/02 12 E0245 NU 150.00 01

313718 150.00 0.00 150.00

Signature On File
09/13/02

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500688.061.0064

313692

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 8-9-02

NAME Christopher Reader
ADDRESS [redacted] 3340
CITY, STATE, ZI [redacted] -1971 03102000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	31	Freedom Condom Caths		
2		#8200		
3		A4358	1-13.00	
4				
5	2	deg Bags #15010 2		
6		A4358	2-14.00	
7				
8	2	Nite time drain bags		
9		#5900 A4357	2-2.00	
10				
11		59654		
12				
13		Frederick C		
14		Young Becoming Martinez		
15				
16		200004168411		
17				
18				

RECEIVED BY Billed 8-16-02

TAX
TOTAL

35805

313699

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 8-9-02

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2			
3	1 #9803 Hollister Evt. Tubing		
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
RECEIVED BY		TAX	
		TOTAL	

Dawn Lester

35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

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X

X West Virginia Workers Comp.

X

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FREDERICK C MARTINEZ 00/00/00 00/00/00

59654

2000046841

08/09/02	12	A4358 NU	55.00 31
08/09/02	12	A4358 NU	14.00 02
08/09/02	12	A4357 NU	20.00 02

313692 89.00 0.00 89.00

Signature On File
08/16/02

5507390150

500688.061.0067

E TANK

Ebenezer Obenza
333 Laidley Street
Charleston WV 25301
D49415
347-6640

08-09-02 08:25 From- T-267 P.03/06 F-696

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.

Date	Time	Complete top portion with each Level of Care change. Indicate order with a Check Mark.
		☐ Outpatient Procedure: ____ (procedure) for ____ (medical reason).
		☐ Place in Outpatient Observation Services for ____ (medical reason).
		☐ Admit as inpatient for ____ (medical reason).

Physician Signature: ____

Date	Time	Additional Orders: (Dates/Times required)
8/8/02	9:25PM	Refer to Social Worker in A.M. for possible need for Home Equipment for home safety (i.e. shower chair, walker) bathtub handle etc.) and Home Health follow up for continuing physical therapy for home safety and neuro checks for possible recurrence of [illegible] Physical therapy for home equipment recommendations for patient's safety
8/9/02	0050	Chart check [illegible]

Allergies & Sensitivities ☐ NKA

Weight	Height	Diagnosis

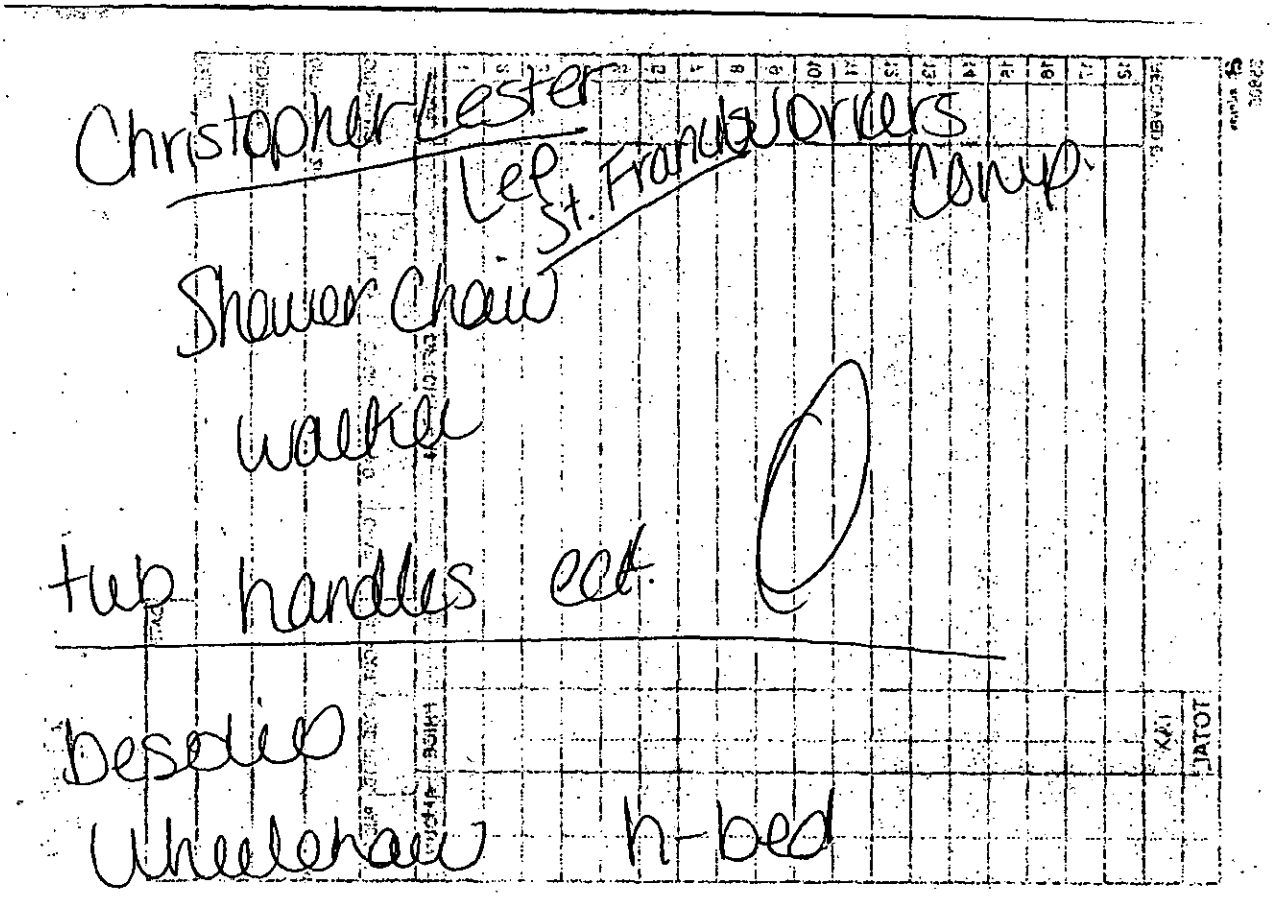
PATIENT ID

Physician's Orders
T4001 Rev 4/00 (RC# 0914040)

CHART

(2

DO NOT WRITE ORDERS UNLESS RED # APPEARS


Christopher Lester
Lee St. Frandsworkers camp.
Shower Chair
walker
tub handles ect.
bedside
wheelchair
h-bed